

F. Payment for Swing Bed Days

Acute care facilities will be reimbursed for qualifying skilled and intermediate care Medicaid patients in accordance with the daily rate schedule shown below.

October 1, 1992 - September 30, 1993	\$62.67
October 1, 1993 - September 30, 1994	67.22
October 1, 1994 - September 30, 1995	70.36
October 1, 1995 - September 30, 1996	75.84
October 1, 1996 - September 30, 1997	79.01
October 1, 1997 - September 30, 1998	83.38
October 1, 1998 - September 30, 1999	86.69
October 1, 1999 - September 30, 2000	92.64
October 1, 2000 -	96.85

This rate calculation is described in the Nursing Home State Plan Attachment 4.19 D, page 33, paragraph H.

G. Payment for Administrative Days

Acute care facilities will be reimbursed for Medicaid eligible skilled or intermediate patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient hospital stay and will be covered in any hospital as long as a nursing home bed is not available. Reimbursement for administrative days is described below.

1. Each administrative day will be paid in accordance with the rate schedule shown below. This daily rate will be considered payment in full. There will be no cost settlement. This rate is a combination of the swing bed rate, as defined above, plus the Alternative Reimbursement Method (ARM) rate for pharmaceutical services.

October 1, 1994 - September 30, 1995	\$73.98 (ARM \$3.62)
October 1, 1995 - September 30, 1996	79.68 (ARM 3.84)
October 1, 1996 - September 30, 1997	83.23 (ARM 4.22)
October 1, 1997 - September 30, 1998	88.02 (ARM 4.64)
October 1, 1998 - September 30, 1999	91.79 (ARM 5.10)
October 1, 1999 - September 30, 2000	98.21 (ARM 5.57)
October 1, 2000 -	103.85 (ARM 7.00)

2. A rate of \$180.00 per day will be available for administrative day patients who require more intensive technical services (i.e. patients who have extreme medical conditions which require total dependence on a life support system). This rate was determined by cost analysis of:

- a. A small rural S. C. hospital which was targeted to set up a ward to provide services for this level of care and
- b. An out-of-state provider that has established a wing in a nursing facility to deliver this type of service.

This per diem rate will represent payment in full and will not be cost settled.

H. Payment for One-Day Stay

Reimbursement for one-day stays that group to per discharge DRGs (except deaths, false labor, normal deliveries (DRG 373) and normal newborns (DRG 391)) will be reimbursed a DRG per diem. A DRG per diem is equal to reimbursement for applicable DRG divided by the average length of stay for that DRG.

I. New Facilities

1. Prospective payment rates for facilities with finally-settled base year cost reports which do not reflect 12 full months of operation or were not in operation during the base year will be determined as follows:
 - a. For hospitals under the Hybrid system, payment will be at the statewide average for the appropriate DRG plus a percentage add-on for projected capital and medical education costs plus outlier payments as applicable.
 - b. For freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities plus projected capital and medical education costs as applicable.
 - c. For Residential Treatment Facilities, payments will be based on a statewide average of all the RTF rates.
2. A new facility will submit its projected capital and medical education cost to the DHHS on the forms and in the format prescribed by the DHHS.
3. The rate for a new facility will apply until recalculation of the base year.
4. A new facility will not qualify for disproportionate share payments until the appropriate hospital fiscal year information is available.

J. Out-of-State Facilities

Payments to out-of-state facilities will be paid according to one of the following methods.

1. Contracting facilities in border states which submitted completed South Carolina specific Medicaid cost reports for the base year and other required documentation will be paid in accordance with in-state facility procedures.
2. When a rate has been set for a provider during a PPS rate period and

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the provider decides not to contract with the South Carolina Medicaid Program (SCMP) at anytime during that period, the facility will receive the set rate (with inflation applied if applicable).

3. Any provider approved to contract with the SCMP for which a facility-specific rate has not been calculated, will receive the statewide average rate. Facility-specific add-ons for Direct Medical Education, Indirect Medical Education and Capital may be calculated with the submission of information requested by the DHHS. The facility must send a written request in order for the DHHS to consider facility specific add-ons.

K. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a South Carolina hospital-specific Medicaid cost report for the base year because the facility did not participate in the South Carolina Medicaid program at that time, will be determined as stated in I 1 a, b and c of this section.

L. Small Hospital Access Payments

Effective October 1, 1999, small hospital access payment adjustments will be paid to eligible hospitals in 4 quarterly installments throughout the year. In order to be eligible for this payment a hospital must meet the criteria defined in Section II 32 of this plan. The payment amount is equal to 13.5% of each qualifying hospital's total 1997 Medicaid revenue and will be allocated between inpatient and outpatient services.

M. High Volume Adjuster Payments

Effective October 1, 1999, high volume Medicaid adjuster payments will be paid to eligible hospitals in 3 installments throughout the year. In order to be eligible for this payment a hospital must meet the criteria defined in Section II 13 of this plan. Qualifying hospitals will be eligible to receive a payment from the high volume Medicaid adjuster fund.

N. Newborn Hearing Screening Payments

Effective October 1, 2000, qualifying hospitals (see Section I C 18) will be reimbursed for Medicaid newborn hearing screenings. Payment adjustments will be made to pay \$26 per Medicaid newborn hearing screening.

VII. Disproportionate Share

A. Payments

Disproportionate share hospital (DSH) payments shall be made in accordance with the requirements of Section 1923 of the Social Security Act and the South Carolina state legislature. DSH payments will be paid to those facilities meeting the requirements specified in Section II 11.

1. Effective October 1, 2000, DSH payments will be set as follows:

- a. Public hospital DSH payments will be equal to each hospital's inflated upper payment limit adjusted by the new Medicaid revenue paid to hospitals. New Medicaid revenue includes rate increases, high volume adjuster payments, small hospital access payments and newborn hearing screening payments.
- b. Non-public hospital DSH payments will be equal to 90% of each hospital's inflated upper payment limit adjusted by the new Medicaid revenue paid to hospitals (as defined in a above).
- c. SC Department of Mental Health (SCDMH) hospital DSH payments will be equal to each hospital's inflated upper payment limit for SC uninsured patients.

2. Effective October 1, 2000, each hospital's upper payment limit reflects their inflated fiscal year 1998 unreimbursed Medicaid and uninsured SC patient cost with the exception of SCDMH hospitals (see 1 c above). Additionally, the cost limit of DSH hospitals designated as Level I trauma centers will include the unreimbursed extraordinary costs for the following services related to Level I centers: emergency room physicians, intensivists, CRNAs and ambulance. Inflated fiscal year 1998 unreimbursed costs for these trauma services for SC Medicaid and SC uninsured patients will be included in the DSH upper payment limit.

3. The following HCFA Market Basket indices will be applied to the hospitals' fiscal year 1998 base year cost.

Calendar year (CY) 1998	2.8%
CY 1999	2.4%
CY 2000	2.9%

Inflation will be applied using the midpoint-to-midpoint inflation method. DSH payments are paid during the state fiscal year (SFY), therefore, inflation will be applied through December 31st, the midpoint of the SFY (July 1st through June 30th).

4. All disproportionate share payments will be made by adjustments during the applicable time period.

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B. Additional Requirements

All qualifying hospitals must adhere to the following rules as set forth in the memorandum of agreement between all participating hospitals and the South Carolina Medicaid Program.

1. The Provider's board chairman and either chief executive officer or chief financial officer shall meet with the DHHS's staff to ensure understanding of the DSH program;
2. The Provider agrees to participate in a peer review system to perform reviews of data resulting in DSH eligibility. Peer review and certification by the peer review group to the DHHS that the data is reasonable may be a prerequisite to a hospital receiving a DSH payment based on the data. Any dispute about the validity of the data must be resolved between the affected hospital, the peer review group and the DHHS;
3. The DHHS will escrow funds and make DSH payments to those hospitals deemed eligible by DHHS. The State Auditor's Office (SAO) may be asked to perform a comparison of data based on agreed-upon procedures subsequent to payment;
4. The Provider agrees to be responsible for supplying acceptable documentation to substantiate the allowable unreimbursed costs in the event of a HCFA audit. If the audit results in a payback, the Provider is responsible for the payback amount. This will apply to DSH payment disallowances for payments made on or after October 1, 1999;
5. All payments are prospective. Only recoupments resulting from negative adjustments to data will be allowed.

VIII. Changes to the Prospective Payment Rates

A. Future Redetermination of Prospective Payment Rates

1. In future years, prospective payment rates for acute care facilities will be established by trending forward the base year prospective payment rates by applying an inflation factor, as defined in Section IV, for the prospective payment year.
2. The outlier set-aside, as described in Section IV of this plan may be recalculated periodically.
3. The DHHS will recalculate the base year prospective payment rates as the agency deems necessary. Recalculation of the base year may involve recalibration of the relative weights, use of a more recent cost report base year or both.
4. The DHHS may recalculate the psychiatric residential treatment facility per diem rate each year based on a prior year's cost report data.

B. Rate Reconsideration

1. Providers will have the right to request a rate reconsideration if one of the following conditions has occurred since the base year:
 - a. Changes in case-mix since the base year. Such requests will be accompanied by documentation of the case-mix change using DRG case-mix index and severity of illness measures. Use of the DRG case-mix index alone is not satisfactory for rate reconsideration under this part. The severity of illness study may be based on a statistically valid random sample of Medicaid patients treated in the facility on an annual basis. If a sample is used, the sampling methodology including the standard error value will be included in the documentation.
 - b. An error in the facility's rate calculation. Such request will include a clear explanation of the error and documentation of the desired correction.
 - c. Extraordinary circumstances, such as acts of God, occurring since the base year and as defined by the DHHS. Such requests will be submitted along with documentation that clearly explains the circumstance, demonstration that the circumstance was extraordinary and unique to that facility, and the expenses associated with the circumstance.
2. Rate reconsideration will not be available for the following:
 - a. The payment methodology, case-mix adjustment, relative weights, inflation indices, DRG classification system.
 - b. Inflation of cost since the base year.

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- c. Increases in salary, wages, and fringe benefits.
3. Requests for rate reconsideration will be filed in accordance with procedures described in the Rate Reconsideration Manual that can be obtained upon request, from the Division of Acute Care Reimbursement. Rate reconsideration requests will be submitted in writing to the DHHS and will set forth the reasons for the requests. Each request will be accompanied by sufficient documentation to enable the DHHS to act upon the request. Rate reconsiderations for errors in the facility's rate will be submitted in writing within 30 days of the rate notification.
 4. The request will be forwarded for review to the Division of Acute Care Reimbursement. This Division will review all requests for rate reconsideration and will issue a decision in writing to the provider.
 5. The provider will be notified of the DHHS's decision within 90 days of receipt of the completed request.
 6. Pending the DHHS's decision on a request for rate reconsideration, the facility will be paid the prospective payment rate currently in effect, as determined by the DHHS. If the reconsideration request is granted, the resulting new prospective payment rate will be effective the later date of:
 - a. The receipt of the request and supporting documentation requested by panel; or
 - b. The first date of the prospective rate year, should the rate reconsideration be granted before this date; or
 - c. The date on which the asset leading to the expenditure was placed into service.
 7. In no case will a rate reconsideration revision be granted if it will result in a facility's reimbursement exceeding what would have been paid under Medicare principles of reimbursement.
 8. Rate reconsiderations granted under this section will be effective for the remainder of the prospective rate year. Requests and documentation will be kept in a facility file and may be automatically reviewed in the following year if the panel has determined that the condition will continue to exist. The facility will be asked in future years to supply only necessary updated information.
 9. Psychiatric residential treatment facilities may request a rate reconsideration within 30 days of receiving their rates. The rate reconsideration may be filed for the following circumstances:
 - a. An error in the facility's rate calculation.

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- b. Amended costs and statistics submitted within 30 days of the receipt of notification of rates.

C. Appeals

1. A provider may appeal the DHHS's decision on the rate reconsideration. The appeal should be filed in accordance with the procedural requirements of the South Carolina Administrative Procedures Act (SCAPA) and the DHHS's regulations.
2. A provider may appeal the Capital and/or Direct Medical Education Final Settlement. The appeal shall be filed in accordance with the procedural requirements of the SCAPA and the DHHS's regulations.

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2. Psychiatric Residential Treatment Facilities

All psychiatric residential treatment facilities will submit the HCFA-2552 form as well as a certified audited financial statement. The HCFA-2552 will be completed using each facility's fiscal year statistical and financial information. Each facility will be required to submit these documents within one hundred and fifty (150) days of the last day of their cost reporting period.

C. Audit Requirements

All cost report financial and statistical information as well as the medical information contained on claims, is subject to audit by the DHHS or its designee. The audited information may be used for future rate calculations, inpatient capital and direct medical education cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

1. Cost reports of non-disproportionate share hospitals will be desk-audited in order to calculate capital cost settlements. Capital cost will be settled at 100% of total allowable Medicaid inpatient capital cost for service dates on or after October 1, 2000, and may be processed within 2 years after the end of a hospital's cost report period. Capital cost will be settled at 85% for service dates prior to October 1, 2000.
2. Supplemental worksheets submitted by hospitals qualifying for disproportionate share payments will be reviewed for accuracy. No additional payments will be made as a result of these reviews. Adjustments will be made only when reviews uncover overpayments or result in loss of disproportionate share status.
3. Medical audits will focus on the validity of diagnosis and procedure coding for reconciliation of appropriate expenditures made by the DHHS as described in A of this section.
4. Retrospective cost settlements will apply to RTFs as follows:
 - a. There will be no retrospective cost settlement for psychiatric RTFs when audited base year cost data is used to set the reimbursement rate.
 - b. There will be a retrospective cost adjustment for psychiatric RTFs when an interim rate is set on unaudited base year cost data. If the interim rate includes subsequent period add-ons, a retrospective cost adjustment will be performed on this subsequent period cost. Only recoupments resulting from negative adjustments will be allowed.
 - c. There will be a retrospective cost settlement for state owned and operated psychiatric RTFs. These will be settled at 100% of allowable cost.
 - d. There will be no retrospective cost adjustment for RTFs that are paid the statewide average rate.

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